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Evaluation of the MassHealth Quality Improvement Program

Final Report

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EVALUATION OF THE MASSHEALTH QUALITY IMPROVEMENT PROGRAM

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ABBREVIATIONS AND ACRONYMS

AP	Action Plan. Specific plan to improve quality of care on the individual practice level in the PCC Plan. Designed by a Regional Network Manager in collaboration with the staff of a primary care case management practice in the PCC Plan.
BHP	The Behavioral Health Program. The component of MassHealth that oversees mental health and substance abuse services.
CHC	Community Health Center serving as a primary care provider in the PCC Plan. May also be a provider in one or more MCO Plan network(s).
DMA	Division of Medical Assistance, the state agency responsible for administering the Medicaid program.
MassHealth	The Massachusetts Medicaid program administered by the Division of Medical Assistance.
MCO	Managed Care Organization
MCO Plan	Component of MassHealth responsible for managed care organization policy development and oversight of the managed care organizations contracted to enroll MassHealth members. The MCO Plan covers about 15% of MassHealth beneficiaries.
NMS	Network Management Services. Previous network management vendor for the PCC Plan.
OPD	Outpatient Department. Hospital outpatient departments serving as primary care providers in the PCC Plan. May also be providers in one or more MCO Plan network.
The Partnership	Massachusetts Behavioral Health Partnership. The vendor responsible for implementation of the PCC Plan profiling initiatives, for oversight of behavioral health services in the PCC Plan and in MassHealth fee-for-service beneficiaries, and for oversight of the behavioral health services provided by MCOs participating in the MCO Plan.
PCC	Primary Care Clinician, could be an individual provider, group, or office.
PCC Plan	Primary Care Clinician Plan. MassHealth's primary care case management program that about 46% of MassHealth beneficiaries are enrolled in.
PIMS	Performance Improvement Management Services component of the Massachusetts Behavioral Health Partnership. Service which manages day-to-day oversight of PCC Plan quality monitoring and improvement activities. Replaced NMS. Contract start date was 7/01/02.

Profiling Initiative	The aspects of the PCC Plan quality monitoring and improvement process that work directly with individual PCC Plan providers. Main activities include creation of practice-level Profile Reports, onsite meetings with individual practices to review these reports and to develop action plans to improve quality.
QIP	Quality Improvement Projects. Formal MassHealth activities focused on specific quality issues such as appropriate use of Emergency Services, Asthma management, Diabetes management, and Well-Child services.
QM/QI	Quality Monitoring/Quality Improvement
RNM	Regional Network Managers. Staff members of the Massachusetts Behavioral Health Partnership who work directly with PCC Plan providers on quality monitoring and quality improvement activities.
Solo Practice	A primary care provider consisting of only one physician and associated staff.

EXECUTIVE SUMMARY

Quality monitoring and improvement are important activities in managed care organizations, intended to promote medical care consistent with clinical guidelines or address consumer satisfaction issues. While it is common for managed care organizations to use a variety of approaches to quality monitoring and improvement, the use of these techniques in a Medicaid primary care case management is unusual. Since 1995, the Massachusetts Medicaid program has implemented policies and procedures in its primary care case management program that emulate managed care organization quality monitoring and improvement practices, including profiling individual primary care practices. Given the problems states have had attracting or retaining managed care organizations in the Medicaid market, it is valuable to understand what may be transferable from this program to other states, as well as the associated challenges and limitations to the Massachusetts approach. This report provides information about the full range of quality monitoring and improvement activities across MassHealth, while focusing on the activities in the primary care case management program.

Massachusetts has invested substantial resources in quality monitoring and quality improvement activities as part of its Section 1115 Medicaid waiver program, MassHealth. There are two components to MassHealth: managed care organizations and a primary care case management program known as the Primary Care Clinician Plan. Massachusetts incorporates expectations regarding quality improvement activities in its contracts with each managed care organization and works directly on quality improvement activities with the Primary Care Clinician Plan providers in a unique program emulating managed care plan practices.

Quality improvement goals are set on an agency-wide basis by senior-level MassHealth staff. The Primary Care Clinician Plan and the Managed Care Organization Program staff then develop specific activities to support the agency goals, as well as developing additional goals of their own. These two components of MassHealth coordinate on Health Employer Data and Information Set activities, on the Consumer Assessment of Health Plans-based annual member survey, and on other broad-based initiatives. In the Managed Care Organization Program, the actual development and implementation of additional quality improvement activities is delegated to each individual managed care organization. In the Primary Care Clinician Plan, the state uses claims to analyze and report service delivery rates on the practice level and then contracts with a vendor to work directly with individual medical practices on quality improvement activities. The vendor works with the individual medical practices, disseminating practice profiles through biannual in-person visits to each individual practice. These meetings are also used to engage the practice in a dialogue about the challenges each practice faces, to discuss what factors contribute to the profile statistics, and to develop appropriate and specific action plans intended to improve provider performance. The Primary Care Clinician Plan quality monitoring/quality improvement activities are resource intensive. In addition to the Division of Medical Assistance's 4.36 full-time equivalent staff positions for quality monitoring/quality improvement in the Primary Care Clinician Plan, computer resources, and printing costs for educational materials provided to the practices (\$48,000 was spent between July 2000 and June 2001 on program support materials), the most recent vendor contract was for \$1.1 million dollars (October 2001 to September 2002).

Primary Care Clinician Plan providers we interviewed generally commended the onsite meeting process, the development of action plans specific to their practices, and the opportunity to learn from vendor staff about systems used by other providers, and they highly valued the educational materials Massachusetts provides to them. Several described implementing recall and reminder systems in response to the Primary Care Clinician Plan quality monitoring/quality improvement activities. Smaller practices, in particular, benefited from receiving information about their own patterns of care and the newly revised and more current reports identifying patients in need of preventive services. Some of the larger practices, which deal with multiple managed care plans and have their own data systems in place, were more concerned by the limitations of claims-based analyses of practice patterns and bothered by the varying quality monitoring/quality improvement requirements imposed by multiple payers. In addition, providers were frustrated with the lack of accurate beneficiary phone numbers and addresses available from the state, which limits the providers' ability to conduct effective outreach to new patients.

Despite the resources invested and the changes made at the individual practice level in response to these efforts, there is little empirical evidence of an impact on the quality of care received by MassHealth's beneficiaries. The lack of observable changes is at least partially a function of the lengthy quality improvement cycle, changes in measure specification that do not permit meaningful comparisons across years, relatively short beneficiary eligibility spells, and problems inherent in claims-based performance measurement. The changes some providers report in their practice as a result of the quality improvement efforts, such as implementing recall and reminder systems, suggest that improvements should become observable over time. While Massachusetts had intended to provide rewards or sanctions to managed care organizations and Primary Care Clinician Plan providers based on performance standards or compliance with quality monitoring/quality improvement mandates, the state has not been able to do so. The state has been hesitant to take any actions that could reduce access for the Medicaid population and further realizes the limited accuracy of claims-based profiling as a source of information about processes of care.

Conclusions and Recommendations

Massachusetts is actively incorporating managed care practices in a primary care case management program. It is clear that the program has real strengths and also problems that other Medicaid agencies should consider in approaching similar quality improvement strategies. The strengths include: use of process measures that are credible to providers and which they can address; a well-developed system of working with individual medical practices and tailoring quality improvement plans to each practice; network management staff who work effectively with the medical practices; provision of useful beneficiary education materials; and redesign of MassHealth's own procedures in response to feedback from the Primary Care Clinician Plan providers. Clinical involvement in the selection and development of the measures and in working with the practices contributes to the appropriateness of the activities and the positive response from many providers. The collaborative approach taken with practices to understand what factors contribute to the reported service rates and to develop action plans is consistent with quality improvement principles including creating an open, safe environment, encouraging diverse viewpoints, and negotiating agreements. Providers are very pleased with the recently

revised and much more timely reports that provide the names of patients who may be in need of follow-up. Perhaps most important, MassHealth staff understand the limitations of the profile data and use these data as a starting point for dialog with individual medical practices, not as the basis for providing rewards or sanctions.

Weaknesses or limitations include those that all states or payers face in the use of claims-based profiling and some specific to Massachusetts. Limitations to the accuracy of claims-based profiling are clear and many are unavoidable. Claims reflect services billed for, not all services delivered. Services may be provided but not within the timeframe specified and billing errors can also contribute to under-reporting of services actually provided. While performance measures provide some insight into the quality of care delivered, they have limited utility as a quality improvement tool because there are other systems issues at play and because providers need additional guidance and support to improve the quality of service delivered. The lack of up-to-date addresses and telephone numbers for beneficiaries who may be in need of follow-up is the single most frustrating issue for Primary Care Clinician Plan providers trying to conduct effective outreach. There is a substantial lag time between the periods of performance and dissemination of the profiles, decreasing the salience of the information to providers. While more timely reports designed to enhance outreach activities address many of the providers' concerns about the data lags regarding individual patients who may need follow-up, there may be other ways the time line for the routine profiling reports could be reduced if the resources were available. In addition, by approaching all practices with the same level of intensity, regardless of size, performance, or access to other ways to analyze their own performance, Massachusetts may not be targeting its efforts most effectively. As a result, state resources may not be used most efficiently, and large practices with internal quality monitoring/quality improvement procedures feel time spent on Primary Care Clinician Plan activities is redundant.

States must clearly understand that claims-based data is not a complete source of information about services provided and approach working with their providers with this understanding. Because of the limitations of claims data, states should approach providing incentives or rewards tied to performance very cautiously.

Finally, Massachusetts is investing more resources in these activities than are available in many other states. Indeed, whether Massachusetts can sustain the current level of investment given recent budget pressures remains to be seen. States with fewer resources to draw upon should consider developing fewer measures, e.g., focusing on well-child visits, and consider more targeted approaches to on-site work with individual practices. Appropriate targets would include specific provider types, such as solo practitioners with a high proportion of Medicaid beneficiaries in their panels, who would benefit most from the opportunity to better understand their patient panels. Alternatively, a state could focus on practices whose profiles suggest poor performance.

1. INTRODUCTION

1.1 Overview

This report describes and evaluates quality improvement (QI) activities conducted by the Massachusetts Medicaid program under the Commonwealth's Medicaid section 1115 waiver. Massachusetts incorporates expectations regarding QI activities in its contracts with managed care organizations (MCOs), and works directly on QI with primary care clinicians (PCC) in its primary care case management program. As many state Medicaid programs are unable to attract MCOs or have plans exiting the Medicaid market, this state's experience incorporating QI activities in a primary care case management program may be particularly useful to other states. As a result, we have focused on these activities in this report, and on practice-profiling activities in particular. The objectives of this report are to describe specific activities in Massachusetts' primary care case management program and with MCOs, to describe the organizational structure supporting these activities, and to evaluate aspects of the QI activities directed to the primary care case management program. The report includes examples of QI initiatives and how they have been selected and implemented. Finally, we discuss lessons learned that may be useful to other states considering implementing similar activities.

This chapter includes background information about quality monitoring and improvement in health care and about the structure of the Massachusetts Medicaid program, the section 1115 waiver, and Medicaid managed care arrangements. Chapter 2 is a brief description of the case study methodology used to collect the information incorporated into this report. In Chapter 3, we describe the QI activities conducted by the Massachusetts' Medicaid department including the formal Quality Improvement Project (QIP). The structure, function, and implementation of the quality initiatives are illustrated in order to present a clear picture of diverse and common strategies utilized by the PCC and MCO programs. In Chapter 4, we present findings from our evaluation of the PCC Plan Quality Monitoring/Quality Improvement (QM/QI) activities. Finally, in Chapter 5, we discuss our conclusions and the implications for other states considering utilizing similar approaches to QM and QI in a primary care case management program. Sample materials from MassHealth, detailed information about specific QI projects, and excerpts from the MCO program QM/QI contract specifications are included as appendices.

1.2 Background

1.2.1 Issues in Quality Measurement and Improvement

The literature regarding QM and QI in health care focuses on several themes including: defining aspects of quality, the relative value and availability of process and outcome measures of quality, and approaches to changing physician behavior as the crux of improving quality of care. The Institute of Medicine defines quality of care as "the degree to which health service for individuals and populations increase the likelihood of desired health outcomes and are consistent with professional knowledge." Deficient aspects of care are typically the reason for monitoring physicians' practice patterns. Three classes of process measures are typically reported in the medical literature: (1) patients not receiving beneficial care, (2) receipt of unnecessary treatments, and (3) poorly performed interventions (Becher and Chassin, 2001).

Quality of care can be measured either by looking at the process of care (i.e., the delivery of recommended procedures) or at health outcomes (i.e., morbidity and mortality rates). While positive health outcomes are the ultimate goals of care, outcome measures are difficult to develop and interpret and can be affected by exogenous factors such as the short eligibility periods common in a Medicaid program. Process measures may be more useful and attainable for several reasons. Process measures clearly indicate which processes a clinician did or did not follow, in realms in which clinicians feel accountable. The information from process measures is “actionable,” i.e., the provider can do something about improving processes of care (Rubin, et al. 2001). Case mix adjustment, which can be challenging, is not as relevant for process measures as for outcome measures. Indeed, differences in the delivery of preventive or screening services by patient characteristics (e.g., age, gender, or comorbidities) are relevant information that should not be “case mix adjusted out” of process analysis. While there may be some technical challenges to defining the eligible population in process measurement, the challenges are not as great as the case mix adjustments necessary for meaningful health outcome measurement (Mant, 2001). Furthermore, measurable processes of care occur more frequently (e.g., annual rates of immunization) than specific health outcomes that might derive from the process of care (e.g., cases of whooping cough resulting from missed immunizations), as well as being “immediate, controllable, and rarely confounded by other factors” (Eddy, 1998).

Improving quality of care boils down to changing physician behavior. In a summary of the literature on changing physician behavior, Bauchner, Simpson, and Chessare (2001) identify effective and ineffective strategies. They report little or no impact on physician behavior following didactic continuing medical education presentations, passive distribution of information (e.g., mailings), or audit and feedback approaches. However, small group discussions or case studies, implementation of manual and electronic reminder systems, educational outreach, and a combination of auditing and reporting with specific recommendations and financial incentives have been effective in changing behavior that is associated with improved quality of care. Berwick (1998) offers recommendations for promoting cooperation in health quality including developing a shared purpose; creating an open, safe environment; encouraging diverse viewpoints, and negotiating agreements.

1.2.2 Physician Profiling

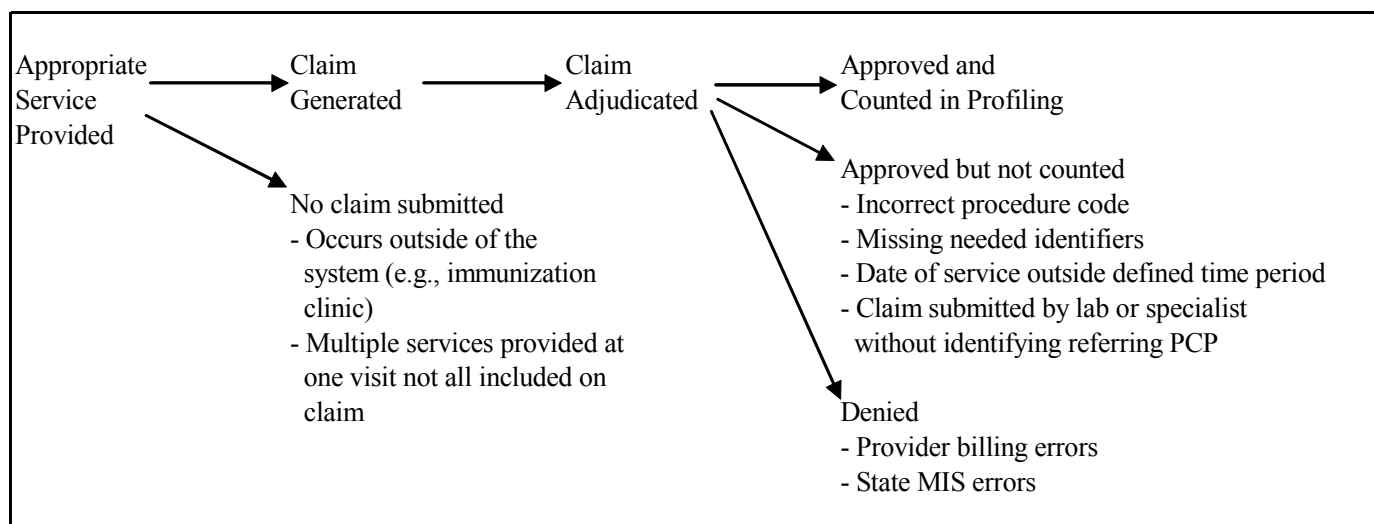
Physician profiling is one means to generate information about processes of care, generally using claims data to generate rates of service delivery linked to enrollment or eligibility data. For example, claims may be used to evaluate mammography rates overall and for subgroups defined by age, race, or ethnicity. Claims are readily available to systematically evaluate patterns of care, can support analysis of treatment patterns for an entire enrolled population, and are much less costly than medical record reviews. However, there are also distinct limitations in the types of treatment that can be observed in claims and problems with the accuracy of data (e.g., Hofer, *et al.*, 1999; and Richman and Lancaster, 2000).

Rates generated from the claims are subject to error in both the numerator (which may be too small if services delivered are not captured) and the denominator (which may be too large or small depending on the specification of eligible patients for inclusion). These inaccuracies can lead to lower reported than actual rates of compliance with recommended treatment guidelines.

As a result, profiles may provide general information about trends, providers whose performance is exceptionally strong or exceptionally weak, or population groups that are systematically under-treated. However, profiles do not always provide precise information about the performance of individual practices or physicians, because claims-based systems do not always capture all of the services delivered.

In Figure 1, we show the many ways a service actually delivered could be missed in a claims-based profiling system, i.e., potential problems with the numerator in generating the profiles. First, an appropriate service could have been delivered outside the system. For example, immunizations are often provided at public clinics, and hence no claim is submitted. Even if the physician is appropriately evaluating whether patients have received necessary services (e.g., by conducting a medical assessment or record reviews), there is no way to indicate this through a claims-based system. Alternatively, there may be no claim when a service was actually provided if the physician referenced only one service on a claim for a visit in which multiple services were delivered. Even when an actual claim for the specified service is generated, there are several ways it may not make it into the rate calculation. Claims submitted for appropriate services may be denied in the adjudication process due to provider billing errors or to problems with the payer's management information system. Claims which make it through the adjudication process may still not make it into the rate calculation if the provider used the wrong billing code, left out or incorrectly entered needed identifiers, or if the claim was submitted by a lab or specialist without including information about the referring primary care provider (if the system uses provider identification numbers to link claims rather than patient identification numbers). Services may also have been provided outside the cut-off dates specified in the measure. While technically the performance measured may be accurate, it does not distinguish between care completely missed and care delayed.

Figure 1
Potential sources of error in claims-based profiling



The combination of possible errors in claims-based performance measures can lead to sizable discrepancies between actual service delivery and practice profile rates. For example, in comparing claims-based immunization data to medical records, Richman and Lancaster (2000) found claims identified only 29% of children under 2 as fully immunized, less than half of the actual services recorded in the medical records (70%). Feedback provided to the physicians in that study yielded an increase of 16% appearing in claims. This 16% improvement still substantially under-reported the services delivered. In addition, the increase could have been achieved solely through correcting billing practices without actually improving quality of care, i.e., ensuring that the remaining 30% of the children receive the recommended immunizations.

Denominator problems result if the patient panels are not correctly identified or the eligible patients correctly specified. Unless the denominator is limited to patients continuously enrolled for an appropriate period of time, the measures may be inappropriate. For example, a measure that is based on annual treatment guidelines is not appropriately applied to patients who enrolled for less than a year. The denominator can also be inaccurate if patients are incorrectly assigned to a particular primary care provider in the enrollment or eligibility files. In other words, patients can be wrongly counted as being on a physician's panel.

Finally, some argue that small sample sizes at the individual provider level are another reason for cautious interpretation of profile reports and may require case mix adjustments (Zaslavsky, 2001). In a study of diabetic care, little of the overall variance observed in diabetes care was attributable to differences in provider (Hofer, *et al.*, 1999). Given this small effect, these researchers calculate that each provider would need to have at least 100 diabetic patients to yield valid results, while in their sample the mean number of patients with diabetes per provider was 61. Alternatively, one could argue that the rate is inconsequential, as the goal should be care according to clinical standards for every patient.

1.2.3 Overview of MassHealth

The state of Massachusetts Medicaid Program, administered by the Division of Medical Assistance (DMA), submitted the application for its "MassHealth" Medicaid 1115 waiver demonstration to the Health Care Financing Administration (HCFA) in April 1994 to extend Medicaid eligibility to more low income individuals and mandate managed care enrollment for many categories of eligibles. HCFA approved the demonstration in April 1995. In July 1996, the state Legislature passed enabling legislation for MassHealth. Implemented in 1997, MassHealth had two central policy objectives: to increase access to health insurance coverage for low-income residents and to curb the growth of the state Medicaid hospital and uncompensated care pool expenditures. The program approached these goals through three strategies: (1) managed care; (2) simplified application procedures; and (3) expanded eligibility. Managed care enrollment in either an MCO or through a primary care case management program was mandated for all nondisabled beneficiaries under 65 years of age without significant third party coverage.

The state had enrolled a large percentage of its Aid to Families with Dependent Children (AFDC) population in managed care through the 1915b-waiver program starting in 1992, expanding the use of managed care to new eligibles under the waiver. Under this program, eligibles choose between the state's PCC Plan, a primary care case management program, or

enroll in an MCO contracted by the state. Individuals who do not select a PCC provider or MCO are autoenrolled with a PCC provider whose panel is open to new patients.

The implied goal of Medicaid managed care is to limit inappropriate services through use of financial incentives to providers. Managed care also provides an opportunity to monitor and improve the scope of services and quality of care delivered to beneficiaries. For this reason, HCFA's approval of the 1115 MassHealth waiver included extensive requirements to assure that the MassHealth managed care programs closely monitor the quality of services that enrollees received so that cost and quality are in proper balance. These efforts built upon quality monitoring and improvement activities that Massachusetts initiated prior to implementation of the 1115 waiver.

1.3 MassHealth Managed Care Program Structure

MassHealth serves its beneficiaries with a combination of standard fee-for-service and two types of managed care arrangements: (1) contracted MCOs (referred to jointly as the MCO Plan and paid on a capitated basis, and (2) a primary care case management program (called the PCC Plan, paid on a fee-for-service basis). Enrollment in one of these two programs is mandatory for Massachusetts Medicaid recipients who are under the age of 65, not institutionalized, and have no other insurance coverage such as SSI or commercial insurance¹. For those in the PCC plan or remaining in fee-for-service, behavioral health services are provided by a capitated carve-out program administered by the Behavioral Health Program (BHP). MCO enrollees receive their behavioral health services from their managed care plans.

Of the three mechanisms (MCO, PCC Plan, and fee-for-service), the PCC Plan is the dominant delivery model. In fiscal year 2000, 46% of MassHealth beneficiaries were enrolled in the PCC Plan, compared to only 15% in any of the contracted MCOs (see Table 1). An additional 35% of beneficiaries were not eligible for managed care enrollment (PCC or MCO), including Medicare/Medicaid dually eligible beneficiaries, others with significant third party resources, and institutionalized beneficiaries. In any given month, another 4% were eligible for enrollment in either a MCO or the PCC Plan but not yet assigned.

1.3.1 PCC Plan

As of August 2001, there were 1250 PCC practices participating in the PCC Plan, including solo practitioners, group practices, community health centers, and hospital outpatient departments. These practices were spread across 1750 clinical sites, and included about 3000 individual physicians in total. These PCCs, like primary care case managers in other states, are expected to coordinate care for their patients and serve as gatekeepers for other services. However, unlike other states with primary care case management programs, the PCC Plan does

¹ Managed care eligibles temporarily receive their Medicaid benefits under fee-for-service as their managed care enrollments are processed.

Table 1
MassHealth enrollments in FY 2000

FY2000	Beneficiaries		Expenditures	
Enrolled in PCC Plan	428,727	(46%)	\$1,214,000,000	(42%)
Unenrolled PCC Plan Eligibles	38,024	(4%)	191,000,000	(7%)
Enrolled in MCO Plans	136,181	(15%)	312,000,000	(11%)
Subtotal	602,932	(65%)	1,717,000,000	(59%)
All other beneficiaries*	319,504	(35%)	1,174,000,000	(41%)
Total	922,436	(100%)	2,891,000,000	(100%)

NOTE: *Includes Medicare/Medicaid dually eligible beneficiaries, individuals under 65 with third party resources, and others not considered eligible for managed care enrollment.

SOURCE: Massachusetts Division of Medical Assistance.

not provide a per member per month capitation payment. Instead, PCCs receive a higher per visit rate for preventive care than for sick visits and, as with all MassHealth providers, an enhanced rate for providing after-hours urgent care. PCC practices have a very limited managed care role compared to standard MCOs, and their patients face fewer controls or restrictions than MCO enrollees. The PCC providers are responsible for most primary and preventive care services for enrolled members on their panel, as well as the coordination and authorization of most specialty and acute care services. PCC providers are expected to conduct out-reach to new members of their panels, assessments of new members within 4 months of enrollment, and each practice must be accessible 24 hours a day. However, beneficiaries are not required to obtain care from their assigned PCC, nor are the PCC providers at risk for any of their patients' health care costs.

Those PCCs with 200 or more PCC Plan enrollees are expected to participate in QI activities as are the MCOs contracting with the state. Of the 1250 PCC practices, 385 had at least 200 PCC Plan enrollees, serving about 85% of the total PCC Plan enrollees. Thus, the QI activities directed to these 385 PCCs target about 40% of all MassHealth beneficiaries.

1.3.2 MCO Plan

The MassHealth MCO Plan is a capitated program administered via contracts with private health plans. Four MCOs were still under contract with MassHealth in 2001: two commercial health plans (Neighborhood Health Plan and Fallon) and two MassHealth/Medicaid-only, approved health plans (Boston Medical Center [BMC] HealthNet Plan and Network Health). The majority of MCO members are enrolled in the Neighborhood Health Plan, a plan with a small commercial enrollment but that predominantly serves Medicaid beneficiaries. The

two Medicaid-only plans are affiliated with hospitals serving a large percentage of uncompensated care individuals. Only Fallon is a mainstream HMO with substantial commercial and Medicare memberships. MCO Plan enrollment has fluctuated since 1997 with declines throughout 1999. In 2000, the service areas for BMC HealthNet Plan and Network Health were expanded beyond the Boston area, increasing the enrollments in these plans. All MassHealth MCOs are paid a per member per month rate depending on member specific Medicaid eligibility categories. There are also special rates for enrollees who are severely disabled and those with HIV/AIDS.

Language to implement and support outreach and QI activities and agreements to adhere to access and other performance standards are incorporated in the MCO contracts as they are in the PCC Plan provider agreements.

1.3.3 Behavioral Health Program

Mental health and substance abuse service provision is directed by the MassHealth Behavioral Health Program (BHP). These services are included in the responsibilities of the MCOs, but PCC enrollees and those exempted from managed care enrollment receive their behavioral health services directly from the Behavioral Health Partnership, a separate, capitated carve-out program. The use of a capitated behavioral health carve-out began in 1992 with the inception of the PCC plan. Additionally, during the first year of the MassHealth 1115 waiver, some MCO members' behavioral health services were covered under this carve-out. The BHP works closely with a number of external agencies, in particular the Massachusetts Department of Mental Health, the chief state mental health authority responsible for defining and monitoring behavioral clinical standards and service delivery models.

A single vendor, the Behavioral Health Partnership ("The Partnership"), is responsible for delivering the carve-out mental health and substance abuse services to the PCC Plan members and for oversight of the behavioral health components of the MCO Plan contracts. This arrangement is designed to promote consistency across the PCC and MCO Plans in access to and quality of care for behavioral health services. The Partnership, in collaboration with BHP, engages in setting performance standards and implementing QI initiatives. These QI oriented activities range from standards for inpatient and outpatient service coordination, to service delivery for homeless beneficiaries, to pediatric clinical issues. In addition, The Partnership holds the contract for PCC Plan network management services, including implementing the PCC Plan QI activities detailed later in this report.

2. METHODOLOGY

This report is based primarily on process evaluation. A process evaluation uses a non-experimental design that describes and assesses operating structures, processes and procedures (Patton, 1980). This qualitative review of MassHealth QI activities is formulated around the following process evaluation activities:

- **Interviews** with key staff at DMA, PCC Plan, MCO Program, and the vendor that conducts many of the PCC Plan QI activities;
- **Observational site visits** with four PCC Plan PCC practice sites during semi-annual PCC Profile Report visits and one MCO during an MCO Semi-Annual Contract Status Meeting;
- **Review of program materials** including materials distributed to providers and beneficiaries, measurement reports and a 1999 evaluation of the PCC Profile Improvement Project; and
- **Interviews with PCC Plan providers**, i.e., practice managers or physicians representing 14 PCC practices that participate in the PCC Plan Profiling activities.

While we collected information and now report on activities in the MCO Plan, our main focus was on the PCC Plan, for several reasons. First, only a small proportion of the MassHealth enrollees are enrolled in the MCO Plan (15%). As in other states, Massachusetts has had trouble recruiting and retaining managed care plans. Second, the use of a primary care case management program to improve quality is an innovative approach, potentially replicable in other states with little or no managed care plan participation. As a result, it is important to understand the PCC Plan QI activities, and the strengths, limits, and costs associated with implementing these activities.

The site visits and formal requests for program documentation occurred between December 1999 and May 2000 and began with introductory visits with the Director of Programs and Implementation, who serves as the primary contact for this evaluation, and key PCC Plan and MCO Program staff. Introductory visits began with a review and discussion of the overall design of the evaluation, including the key project phases and timelines. Staff who attended the introductory visits provided a high-level overview of general program and QI staffing and structure, including their roles and responsibilities with respect to specific QI activities. At the conclusion of the introductory visits, “key” criteria for its PCC Plan and MCO Program Staff, PCC practice sites, and MCOs were identified for subsequent site visits; initial program documentation requests were also made. We also conducted additional telephone interviews with key staff at DMA and at the vendor responsible for QM/QI activities in the PCC Plan for clarification, to fill in information gaps and to assist in developing the PCC Plan provider interviews. These telephone interviews occurred in several phases between 2000 and 2002. In the course of the site visits, telephone interviews, and subsequent follow-up communications, we gathered information about the structure of the PCC Plan and MCO Program, the organization

and management of quality improvement activities, specific QI projects and support materials, and the PCC Plan provider profiling activities.

We obtained and reviewed a variety of program materials and performance measurement reports throughout the site visit period. Such documentation served to clarify, supplement, or elaborate on the programmatic information discussed during the structured interviews and provided substantial background for this report.

The 1115 Waiver Demonstration Protocol Document, Annual Waiver Reports, and Clinical Guidelines Documents provided much of the information on the overall structure and organization of DMA, the PCC Plan, and the MCO Program. Documentation describing general approaches to and specific examples of QI and management at the agency, PCC Plan, and MCO Program level comprised the bulk of the requested materials. Examples of such materials include: Provider Agreements and Program Guides, PCC Profile Reports, Member and Provider Education materials, PCC Plan QIP descriptions, MCO contract language and reporting requirements, MCO improvement goal negotiation and monitoring tools, and annual HEDIS and Consumer Assessment of Health Plans (CAHPS) reports.

In addition to describing the profiling initiative, we sought to evaluate whether the Massachusetts profiling initiative affects physician behavior or has any measurable impact on the desired outcomes. We also sought to understand the degree of burden it imposes on participating medical practices. To contribute to this effort, we interviewed staff from 14 PCC practices. These practice managers, clinical coordinators, and physicians were not randomly selected, hence their feedback may not be representative. They were selected from a list provided by the network management vendor responsible for working with the medical practices on quality monitoring and improvement activities. The practices were selected to include a range of practice types (solo practitioners, group practices, community health centers, and outpatient departments), to include urban and rural regions of the state, and to consist of informants who would be willing to engage in discussion with us. The practices whose staff we interviewed serve almost 30,000 PCC Plan enrollees, representing about 9% of PCC Plan enrollees statewide. We also reviewed sample Profile Reports and a 1999 evaluation of the PCC Profile Improvement Project (Freidman, *et al.*), and we discussed with DMA changes made in response to the 1999 evaluation.

After receiving a list of PCC Practices identified as likely to respond to our request for an interview, we mailed introductory letters explaining the evaluation, how we obtained their names, what we were interested in discussing, and a list of questions for the interview. We followed these letters with phone calls requesting an interview and offered those who were willing to participate the choice of a telephone or an in-person interview. We asked to speak with the staff members most involved in QI activities who routinely met with the network management staff. The interview protocol covered demographic information about the practice and the proportion of their practice composed of MassHealth enrollees; general information about their involvement in the PCC Plan; feedback on the QI process; the impact of the QI activities on their clinical practice; participation in the PCC QI processes; and their recommendations. The results of these interviews are presented in Chapter 4.

3. MASSHEALTH QUALITY IMPROVEMENT ACTIVITIES

3.1 Overview

In this chapter, we describe the PCC Plan Profiling Initiative in detail and provide an overview of the wide range of quality monitoring and improvement activities conducted by MassHealth in the PCC Plan and in the MCO Program. In addition, we provide information about specific, agency-wide QI initiatives and describe aspects of the selection and implementation process of these initiatives. We also provide information about the MCO QM/QI contract requirements. Relevant sections of the MCO contracts, details about specific Quality Improvement Projects (QIP), copies of the PCC Profiling Initiative documents, and sample support materials are included as appendices.

MassHealth staff, agency contractors, and providers engage in a wide range of quality monitoring and improvement activities through essentially decentralized processes. While there is no individual or department overseeing all quality monitoring or improvement activities, many departments and individuals are responsible for specific activities or collaborate on cross-departmental projects, and some activities flow directly from executive level agency goals. QI activities include agency-wide initiatives, applying to both the PCC Plan and the MCO Program, while others pertain to only one or the other. There are also activities specific to individual PCC practices or MCOs. DMA also works directly with hospitals and produces beneficiary education materials, beneficiary surveys, and primary care practice profiling. While specific new initiatives are developed, many quality measurement and improvement activities have become routine and are implemented on an ongoing basis.

Thus, the PCC Profiling Initiative occurs within the context of a broad range of agency-wide, PCC Plan-specific, and MCO Program-specific activities. We provide information about these various other activities, as they further demonstrate the ways that MassHealth emulates managed care practices in its primary care case management program and show the depth of commitment to quality monitoring and improvement at MassHealth. In Section 3.2, we describe aspects of the MassHealth QI goal setting and planning process. Section 3.3 briefly describes activities that are conducted jointly by the PCC Plan and MCO Program, such as HEDIS reporting and Member Surveys, and coordination with the BHP. The central focus of this chapter is found in Section 3.4. We begin Section 3.4 with a description of the role of the contracted vendor responsible for implementing the PCC Plan Profiling Initiative, followed by a description of this key QM/QI activity. To complete the description of MassHealth QM/QI activities, we provide information about MCO Program-specific activities in Section 3.5.

3.2 Agency Goals and Planning

By including QI goals in DMA's executive staff's annual goal setting process, agency-wide goals are established and the DMA leadership signals the commitment of the agency to QI. The annual goal setting and monitoring process includes the Commissioner, Deputy Commissioner, and Assistant Commissioners. QI discussed in the context of other topics, including the agency budget, health care coverage and benefits, agency operations such as

eligibility and enrollment, managed care, and general health care issues. The agency goals generated through this process establish priority areas, providing direction for the program and staff. These goals also signal a level of commitment that can attract the necessary resources to support specific activities within departments, such as Information Systems, that are not dedicated solely to QM/QI activities. The annual goals are disseminated to staff through a presentation at a symposium, review and discussion at senior-level staff meetings, and an announcement distributed with employee paychecks. The PCC Plan and MCO Program then develop specific activities to support the agency goals, as well as developing additional goals of their own. Related activities and goal attainment are reviewed at the end of each fiscal year.

Figure 2 shows DMA FY 2000 Goals related to QI, including some DMA system changes and some requiring implementation at the PCC or MCO level.

In addition to annual goal setting, DMA established a Quality Management Steering Committee of senior-level staff that meets biweekly. Figure 3 shows the senior administrative structure within the Office of Acute and Ambulatory Care, with the shaded boxes indicating the members of the Quality Management Steering Committee. The Assistant Commissioner for the Office of Acute and Ambulatory Care, the Deputy Assistant Commissioner for Program Policy, and the Directors of the PCC Plan, the MCO Program, and the Behavioral Health Program sit on this committee. This committee serves as an avenue for all involved stakeholders within the PCC Plan and MCO Program to discuss quality concerns on an ongoing basis and to make and manage quality related decisions that impact the various units.

3.3 Joint PCC and MCO Plan Quality Initiatives

Although the day-to-day operations of the PCC Plan and MCO Program are distinct, the two units coordinate on a number of quality monitoring and improvement activities. This coordination on aspects of quality monitoring and improvement activities is consistent with DMA's view that these two components combine to serve the MassHealth managed care population. This coordination also supports efficient use of clinical expertise in developing QM/QI activities and measures, and of information resources such as claims and encounter processing. It also provides the opportunity for the learning and knowledge gained through these activities to be broadly shared. Thus, the selection, development, and interpretation of quality monitoring measures applies across both of these components of MassHealth. Specifically, there is coordination in annual measurement initiatives such as HEDIS and Member Survey, in data systems, and in the development and implementation of broad-based improvement initiatives such as MassHealth Goals for Pregnant Women, Children, and Adolescents. The following sections describe these joint activities.

3.3.1 HEDIS Annual Reports

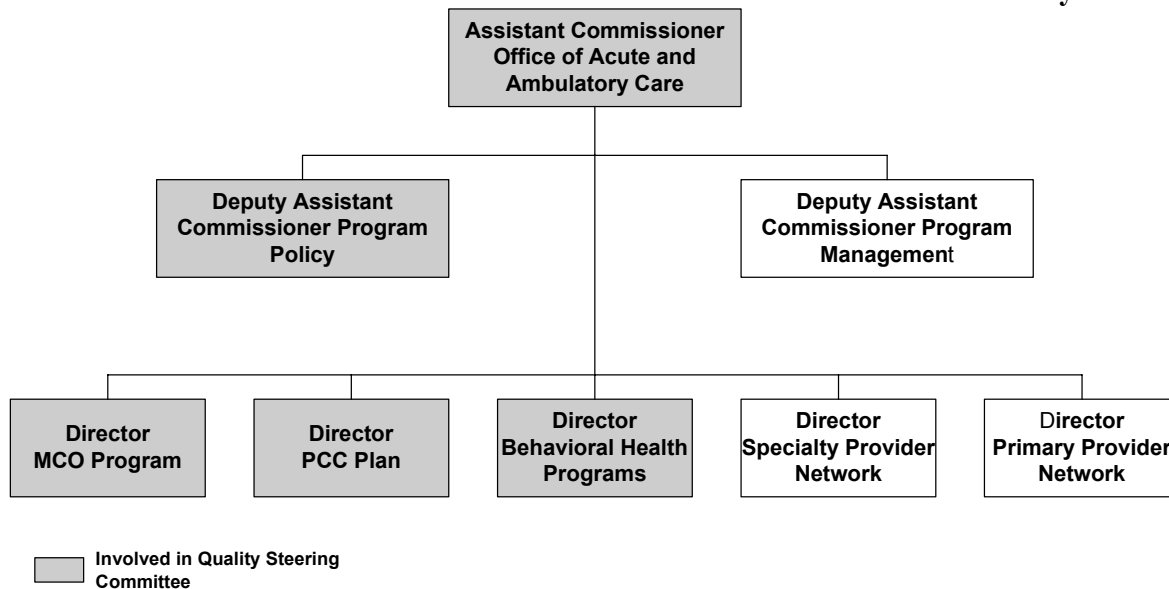
HMOs seeking National Committee for Quality Assurance (NCQA) accreditation are required to report specific measures of utilization annually. NCQA directs that measures be selected from HEDIS. DMA's approach to selecting and implementing HEDIS activities illustrates the high level of coordination across units and the overall investment made by DMA staff in QI activities.

Figure 2
DMA FY2000 Goals

Improve the health and well-being of members <ul style="list-style-type: none"> • Increase by 5% the rate at which 2-year-olds and adolescents are fully immunized • Increase by 5% the rate at which pregnant women receive timely and appropriate perinatal care • Increase by 5% the rate at which nursing facility residents receive pneumococcal vaccinations in order to reduce preventable hospitalizations
Improve DMA's ability to meet members' needs <ul style="list-style-type: none"> • Achieve a call-answering rate of at least 97% • Translate member materials into two additional languages • Reduce by 5% the rate at which members are assigned by default to a plan as a result of their not making an affirmative choice
Improve the service delivery system for members <ul style="list-style-type: none"> • Complete the Senior Care Options procurement • Select physician and aging network partnerships to coordinate seniors' care • Issue an integrated-management procurement for the PCC/Behavioral Health Plans • Increase day habilitation capacity
Improve Information Technology Services <ul style="list-style-type: none"> • Establish a business-analysis function and improve service to system users • Develop a strategic plan to simplify and improve the efficiency of MMIS • Define the requirements for a data warehouse
Manage prescription utilization <ul style="list-style-type: none"> • Implement and evaluate provider and member education initiatives for clinically appropriate antibiotic use • Evaluate member education for clinically appropriate anti-ulcer and benzodiazapines use • Procure an enhanced pharmacy on-line system

HEDIS activities at DMA are overseen by a team composed of a PCC Plan Clinical Project Coordinator, the MCO Program Quality Manager, the Behavioral Health Program Quality Manager, and the Assistant Director for Information Analysis. This team reports to the Assistant Commissioner of Benefit Plans and is responsible for project oversight, including the annual selection of measures; the identification and allocation of data collection, analysis, and reporting resources; and final reporting. DMA is a member of the New England HEDIS Coalition, whose other members are commercial HMOs, in order to stay abreast of activities in the commercial market.

Figure 3
Senior administrative structure of the Office of Acute and Ambulatory Care



Individual HEDIS activities vary in the type and amount of information they require. Some, like immunization rates, are particularly resource intensive as they depend on intensive chart reviews. To minimize the burden on the MCOs and the PCC Plan, DMA adopted a strategy of rotating measures, whereby the entire set of HEDIS measures is considered each year and a subset of measures are selected for collection and reporting. In addition to reducing the data collection burden on plans and providers, this strategy is intended to allow sufficient time between successive HEDIS measurements for the PCC Plan and the MCOs to respond to previous HEDIS findings before reviewing their progress.

The HEDIS team's recommendations are based on several criteria and then subject to review and approved by internal DMA stakeholders, including the directors of the PCC, Behavioral Health, and MCO Program and some of their staff. These selection criteria are:

- the measure is relevant to the MassHealth population or its needs
- the measure is consistent with and relevant for monitoring DMA, PCC Plan, MCO Program and Behavioral Health Program goal attainment;
- the measure must meet a specific and articulated agency or program need for data;
- the measurement resource burden must be considered (e.g., reliance on chart reviews – a limited number of measures requiring chart review are selected in any given year); and
- it must fill an existing data gap or not be available elsewhere. If there is another source for the measure, that source must be considered first.

3.3.2 MassHealth Managed Care Member Survey

DMA conducts an annual Managed Care Member Survey to elicit member feedback on availability and access to services, on utilization of and experience with health services, and member satisfaction with the services delivered by their health plan or provider. The Member Survey is the CAHPS Adult and Child Medicaid Managed Care (Core) Questionnaire, with some additional items from the CAHPS Adult and Child Supplemental questions (e.g., questions regarding behavioral health treatment or counseling and family planning services) and DMA-specific questions (e.g., health plan membership and length of enrollment in the current health plan). The Member Survey is distributed annually to a random sample of members who have been enrolled in either the PCC Plan or one of the MCO Program MCOs for at least 6 months. At the time of this study, only two rounds of the survey had been completed and available. As these two rounds focused on different measures, there were no data by which to evaluate any changes over time.

Member Survey results are used by the PCC Plan and MCO Program to identify opportunities for improvement and determine the focus of QI projects or MCO goals. Eventually, they will also be used to monitor progress towards goal attainment over time. At the time of this study, the PCC Plan was exploring potential activities with DMA's Member Services Unit to address identified customer service issues. The PCC Plan was also working to expand its current PCC Plan HEDIS Report distributed to the PCC practices to include Member Survey results. MCOs are required to review the Member Survey Report to inform their internal member satisfaction improvement initiatives. MCOs must identify those measures where performance is significantly low and submit a detailed improvement plan to the MCO Program Quality Manager. Examples of recent improvement plans include the development of provider site profiles to include language capacity and waiting times and a site-specific telephone survey to measure member experiences regarding access and availability of services, including handicap access, language, and length of time to get appointments. DMA is also using survey results to complete a Report Card Pilot Project, which includes HEDIS and Member Survey Data as a tool to aid members in selecting a health plan.

3.3.3 Behavioral Health Program Quality Improvement Activities

BHP works to promote consistency between the responsibilities of the PCC Plan behavioral health carve-out vendor (the Massachusetts Behavioral Health Partnership) and the MCOs, especially in the areas of access and quality of care. BHP has devoted particular attention to ensuring the development and maintenance, within each contracted MCO, of appropriate behavioral health and substance abuse service infrastructures.

BHP coordinates all behavioral health-related agency-wide and plan-specific QIPs, as well as quality measurement and reporting. One example is the PCC Plan QIP for the Seriously Mentally Ill, a collaborative project with the State's Department of Mental Health and DMA's BHP. The QIP began as a DMA Goal in FY 1999 to improve the coordination of primary and behavioral health care for PCC Plan members with serious mental illness, who are also served by the Department of Mental Health. The QIP also seeks to improve access to PCC Providers and the delivery of primary care services for these members.

3.3.4 Plan-Wide Quality Improvement Projects (QIPs)

DMA develops and implements plan-wide projects (applied to both the PCC Plan and MCO Program) that take a multifaceted approach to changing practice patterns and educating beneficiaries. For example, the goals of the Perinatal Care QIP are to increase prenatal and postpartum care service delivery and ensure that perinatal care services are delivered in accordance with clinical guidelines. This extensive project involves staff from a number of DMA units, including the PCC Plan, Delivery Systems, Member Services, and the Office of Clinical Affairs; as well as representatives from the MCOs and from the Department of Public Health. The resulting team meets regularly to develop strategies and implement projects designed to encourage and facilitate early access to prenatal care, reinforce the importance of going for regular prenatal care, encourage women to make and keep their postpartum visits, and encourage pregnant women to choose a pediatrician for their child. These work groups led to the production of multiple educational materials for both providers and members. Detailed descriptions of the Emergency Services QIP and the Diabetes Management QIP are provided in Appendix A.

3.4 PCC Plan Quality Monitoring and Improvement Activities

In addition to the agency wide activities described in Section 3.3, the PCC Plan conducts network management activities to monitor performance and promote QI. The PCC Plan quality monitoring and improvement activities are extensive and resource intensive. In addition to DMA's 4.36 full-time equivalent staff positions for QM/QI in the PCC Plan, computer resources, and printing costs for education materials (\$48,000 was spent between July 2000 and June 2001 on program support materials), the most recent network management contract for performance monitoring and QI activities was for \$1.1 million dollars (October 2001 to September 2002).

The Partnership manages the QI activities for the PCC Plan, working in conjunction with DMA staff. The Partnership has multiple responsibilities which include managing the behavioral health carve out for PCC Plan and fee-for-service MassHealth beneficiaries, as well as responsibility for implementing QM/QI activities in the PCC. Within the Partnership, the Performance Improvement Management Services (PIMS) component is responsible for the day-to-day management of PCC profiling activities, maintaining a hotline for PCC provider questions, monitoring and verifying provider telephone availability 24 hours a day and 7 days a week. Previously, PIMS network management staff and DMA clinical staff conducted quarterly regional meetings. Due to low levels of attendance, these quarterly regional meetings have been replaced with more targeted forums. For example, PIMS has recently designed forums for behavioral health providers including one for providers who serve a large number of homeless patients and one focused on managing large numbers of patient "no shows".

3.4.1 The PCC Profiling Initiative

PIMS works directly with the individual PCC Plan practices to support QI activities in various ways similar to ways in which individual MCOs might work with providers. The central activity is the PCC Profiling Initiative, involving the dissemination of Profile Reports, providing information about practice patterns and the development of Action Plans to address opportunities

for improvement. PIMS utilizes regional network managers who work with the individual practices across the entire Massachusetts PCC network. In this section, we provide information about how these activities are conducted. In Chapter 4, we evaluate the impact of these activities on PCC Plan practices.

The central QM/QI activities conducted on the practice level are PCC profiling (of each PCC practice, not of individual physicians), on-site meetings with PCC staff, and the development of practice-based improvement activities based on the profiling data. The components of this process, which we describe below, include (1) measurement selection determined by DMA, (2) claims data analysis, (3) creation and dissemination of Provider Profile Reports and Reminder Reports, (4) twice yearly meetings with the individual practice managers or clinicians from each participating practice, and (5) the development and implementation of Action Plans to address QI opportunities (see Figure 4).

Figure 4
Components of the PCC plan profiling initiative

<u>Activity</u>	<u>Responsible Organization</u>
Selection and specification of measures for analysis	DMA
Claims data analysis for use in Profile Reports and Reminder Reports	DMA
Creation of Profile Reports based on claims data analysis	PIMS
Creation of Reminder Reports	PIMS
Biannual Dissemination of Profile Reports via onsite meetings	PIMS Regional Network Managers
Development of Action Plans	PIMS Regional Network Managers and individual PCC Plan Practices

3.4.2 Creation and Dissemination of Provider Profile Reports and Reminder Reports

Practice-level Profile Reports and Reminder Reports (defined below) are generated twice a year for each PCC practice with at least 200 PCC Plan enrollees. The PCC Profile Report includes data on the PCC-specific panel and comparison information on the entire PCC Plan. Measurement selection for the Profile Report is based on MassHealth HEDIS results or other quality monitoring activities suggesting opportunities for improvement. Data for the Profile Report is compiled using paid claims and is generally 12 to 18 months old by the time each PCC receives its report. The data lag is the accumulated effect of waiting 6 months after the reporting period for claims to be filed and the claims adjudication to be complete, and a several month data analysis and report production process.

The Profile Report is composed of a series of performance measures and includes the following sections:

- PCC panel characteristics, summarizing panel enrollment by age, gender, and disability status.
- PCC quartile rankings for performance measures as compared to all other PCC practices that have at least 200 beneficiaries in their panel. At the providers' request, rates are now broken out by site within the PCC practice to help the PCC better understand site performance.
- PCC and PCC Plan performance in specific review periods for the following measures:
 1. Percentage of children receiving the expected number of well child visits in accordance with age specific Massachusetts Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule;
 2. Emergency room visit rates;
 3. Percentage of eligible women receiving cervical cancer screening;
 4. Percentage of eligible women receiving breast cancer screening;
 5. Percent of enrollees with asthma utilizing the emergency room, observation beds or requiring hospitalization; and
 6. Percent of members with diabetes receiving biannual and quarterly HbA testing, and annual retinal exams.

For each measure, backup detail derived from Medicaid administrative data is provided about each person whose care might indicate a need for follow-up, e.g., either having missed a recommended service or having been seen in the emergency room. This data includes the date enrolled with the PCC practice and date last seen by the PCC in the last calendar year. For emergency room visits, data are also provided regarding office visits around the date of the emergency room visit to identify whether the beneficiary was sent to the emergency room after seeing the physician and whether there was any follow-up after the emergency room visit.

While the Profile Reports serve to measure and communicate performance on the practice level, the backup, patient-specific data provide the type of information needed to support QI. This information is intended to assist the providers in their outreach efforts, as well as to identify the root cause of any barriers to care. However, given the lag between the measurement period and the dissemination of the backup details associated with the profile report data, this information is out of date. By the time the practice receives the information, some patients have received the recommended services or are no longer on the provider's panel. While the performance measures included in the Profile Report are useful to monitor trends or identify patterns of care, the Profile Reports are not as useful as QI tools, i.e., for identifying specific beneficiaries in need of services. To address this issue, DMA introduced the Reminder Report that includes more current member detail about needed services for panel members. Mailed out every 6 months, the Reminder Report data is not limited to paid claims (and hence not delayed by the adjudication process) and is only about 6 weeks old when the PCCs receive it. The PCCs

are encouraged to use the Reminder Report as an outreach tool to track and contact patients in need of services.

Sample Profile Reports, Reminder Reports, and the Profile Report Users Guide are included in Appendix B.

3.4.3 Performance Improvement Site Visits and Action Plan Development

The PCC Plan links the distribution of the Profile Reports with in-person meetings of PIMS staff. PIMS regional network managers meet with the practice manager, medical director, or another representative of each PCC practice. These site visits are a core component of the PCC Plan profiling activities and serve several purposes. In the course of these meetings, PIMS staff review the Profile Report, answer questions, review improvements since the last Profile Report, and initiate discussion of areas for improvement. DMA views the meetings as an opportunity to get to know the practice and collect information that is necessary to develop and implement an Action Plan designed to address an identified opportunity for improvement. The PIMS staff conducting these meetings include registered nurses with experience in primary care and former practice managers. Clinical backup is provided by medical directors who can address clinical issues and questions raised by participating physicians about the measures, the clinical guidelines, or interpretation of the Profile Report data.

The primary goal of the meetings between the PIMS staff and the practice staff is to work collaboratively to identify appropriate areas for improvement and an Action Plan related to each selected area. Implementation of Action Plans is a requirement for practices participating in the PCC Plan. These Action Plans may include administrative or operational practice improvements such as improved communication with hospital emergency room departments to improve care coordination and minimize emergency room utilization, or implementation of a recall and reminder system for preventive care. As part of the discussion, the PIMS staff share information with the PCC providers about how other similar practices are addressing similar problems.

Action plans are developed over the course of at least two site visits, allowing the PCCs and PIMS staff time to “look behind” or investigate problems suggested by the Profile Reports. Practice staff often check each case cited as having been missed in the Profile Reports. The practices are interested in seeing if low rates of recommended care observed in the report reflect billing errors or other measurement issues, rather than noncompliance with clinical guidelines or practice standards. This investigation period is also an important opportunity for the practice to identify operational factors that contributed to the rates observed in the Profile Reports. For example, one practice noted that the percent of children receiving the recommended well child visits had decreased and found that office staff had stopped sending out reminder postcards.

This staged process has several intended effects. It ensures that Action Plans target actual problems, not artifacts of data collection problems, and that the Action Plans are designed effectively for the individual practice. It also provides PIMS and DMA with the opportunity to learn the extent of problems related to faulty enrollment data or claims-processing problems beyond the control of the PCC practice. A sample Action Plan is provided in Appendix B. At the time of this study, the PCC Plan Action Plans in place included:

- 130 PCC Action Plans to improve well child care
- 207 PCC Action Plans to address emergency room utilization
- 14 PCC Action Plans to improve asthma management
- 95 PCC Action Plans to increase the rate of cervical cancer screening
- 83 PCC Action Plans to increase the rate of breast cancer screening

3.4.4 Educational Materials

Each version of the PCC Profile Report is accompanied by a variety of physician or member educational materials to assist PCC Plan providers in specific clinical performance areas or in their outreach efforts. These materials, developed internally or obtained from another state agency or private affiliation, are available in several languages. Many of these materials have been developed from PCC Plan or agency-wide QI projects. The materials are frequently updated, and additional copies can be requested by the providers. Figure 5 shows the materials available related to childhood immunizations and to emergency room use. Several examples of these materials are included in Appendix C.

Figure 5
Examples of supporting materials distributed to providers

<p>Well Child Materials</p> <ul style="list-style-type: none"> ▪ MassHealth HEDIS Immunization Fact Sheet ▪ “Vaccinate Me Today” Alert Stickers for patient medical records ▪ DPH Immunization Program Vaccine Documentation Requirements and Vaccine Administration Record insert for patient medical records ▪ “Vaccinate Your Children” booklet ▪ Multi-lingual Vaccination Flyers and Massachusetts Health Promotion Clearinghouse Catalog (for ordering additional member educational materials) ▪ CDC Standards for Pediatric Immunization Practices <p>Emergency Department Utilization Materials</p> <ul style="list-style-type: none"> ▪ Member Wallet Card ▪ Member Fact Sheets (“Care Whenever You Need It,” “Before You Go to the Emergency Room: What You Should Know”) ▪ PCC After Hours Urgent Care Enhanced Reimbursement Fact Sheet

3.5 MCO Plan Quality Monitoring and Improvement Activities

The key components of the MCO Plan's QI program are

- MCO contract management,
- Clinical Topic Reviews,
- HEDIS annual report production, and
- The MassHealth Managed Care Survey.

As described previously, the HEDIS and survey initiatives are joint PCC Plan and MCO Program. The following sections provide brief descriptions of the MCO contract management and clinical topic review activities.

3.5.1 MCO Contract Management

The MCO Contract and the associated contract management activities serve as the MCO Program's primary QI tool. While the DMA MCO Program designs activities to improve quality as directed by the DMA agency goals, the individual MCO plans actually implement any QM/QI activities. Therefore, the MCO contracts include standards that define the types and quality of services and care that each MCO must be able to provide to its enrolled MassHealth members. While each MCO under contract is required to meet all of the contract requirements, the following overview is limited to those standards and specifications set forth in the QM/QI and Clinical Initiatives and Care Management sections of the Contract.

QM Contract Standards and Purchasing Specifications. The MCO Program contracts include standards and purchasing specifications. These standards and specifications require that each MCO maintain a well-defined quality management organizational structure and actively support the development and implementation of QI initiatives, particularly those required by the MCO Program.

The QM/QI section of the contract includes structural, organizational, and operational requirements for the MCOs. These requirements apply to both clinical issues and non-clinical issues such as wait times. The relevant sections of the contract are provided in Appendix D and include the following requirements:

- Provide quality of care to improve or maintain enrollees' health
- Utilize the principles of continuous QI and total quality management
- Maintain a QM/QI structure and employ a QM director to oversee all QM/QI activities
- Collect clinical indicator data and report results
- Implement clinical practice guidelines
- Maintain a utilization review function

- Conduct profiling activities at least annually
- Implement clinical initiatives to improve prenatal care, well-child care, asthma management, and care for enrollees with HIV/AIDS
- Implement care management for at-risk populations, including people with disabilities, women with high risk pregnancies, enrollees who are homeless, and children under state custody

Annual Improvement Goals. In addition to the QM/QI and Clinical Initiatives and Care Management requirements, the MCOs are required to participate in DMA's Annual Improvement Goal negotiation and implementation process. Annual Improvement Goals are negotiated in the fall of each year and result in MCO-specific contract amendments. There are two different categories of Improvement Goals: Standard and MCO-Specific. Standard Improvement Goals are applicable to all MCOs under contract and reflect a shared or common opportunity for improvement in a specific area of service or for a specific population. These goals are proposed by the MCO Plan, with specific goal focuses and activities being negotiated with the MCOs. DMA-sponsored Workgroups are established to support Standard Improvement Goals. Standard Improvement Goals generally support a new DMA Initiative (such as pharmacy management), a focused area of contract management (such as behavioral health), or a specific area identified through HEDIS as an opportunity for improvement for DMA (such as perinatal care). In contrast, MCO-specific Improvement Goals focus on the specific or particular opportunities for improvement within an individual MCO. These goals are proposed by the MCOs, with specific goal focuses and activities being negotiated with DMA. MCOs have about two to four MCO-specific Improvement Goals each year, and such goals may be unique to that MCO in any given year.

Each MCO is required to participate in semi-annual Contract Status Meetings, which are organized and facilitated by the MCO Quality Manager. The Contract Status Meetings provide a forum for the MCO Program and other DMA staff to offer the MCO direction towards goal improvement and for MCOs to describe goal improvement activities and progress towards goal attainment.

3.5.2 Clinical Topic Reviews

The MCO Program conducts its annual Clinical Topic Review (CTR) to fulfill the CMS-required independent external review of the performance of the capitated managed care organizations under MassHealth, in accordance with the Social Security Act 1902(a) 30(c). The primary goal of the CTR is to assess the performance of MCOs in focused areas or clinical topics, specifically in regards to access and quality of care. Furthermore, the CTR focuses on medical issues that are of importance to the populations served by MassHealth. In turn, the CTR furnishes the DMA and the MCOs with information including providing:

- the Division's MCO Program with a means for assessing whether the MCOs managing the care of their enrolled members are performing satisfactorily;

- individual MCOs with detailed information about potential areas for improvement; and
- information for use in the annual cooperative Improvement Goal Process, such as new areas for Improvement Goal negotiation.

In 1999, the Division of Medical Assistance contracted with two vendors to conduct the CTR: the Center for MassHealth Evaluation and Research (CMER) at the University of Massachusetts Medical Center and MassPRO, an Independent Peer Review Organization. CMER's responsibilities include facilitating the workshops that lead to the selection of the review topics and detailed review design, overseeing MassPRO throughout the conduct of the CTR, preparing final reports, and facilitating a process for the review of findings with the MCO Program and the individual MCOs. MassPRO's participation includes conducting the sampling, medical record acquisition, and medical record review process. The MCO Program actively participates in the review design. A policy and procedures review is conducted in addition to the medical record review component of the CTR. This policy and procedure review provides the MCO Program with copies of pertinent materials about each topic selected to help inform analysis and interpretation of the MCO results. The materials collected and reviewed include clinical and administrative guidelines and protocols, program descriptions, descriptions of special projects or activities, and clinician and member education tools.

The clinical topic areas outlined in Figure 6, and their corresponding objectives, were selected by the CTR project team for 1999. These topics were specifically designed to be HEDIS "look behinds"; that is, to explore the clinical areas measured by HEDIS in greater detail. The goals of this CTR were to provide the MCO Program and the MCOs with detailed information about the clinical quality of care and to identify specific opportunities for improvement related to these topics.

Figure 6
Clinical review topics and their objectives

Clinical Topic Review	Objectives
Childhood Immunizations	<ul style="list-style-type: none"> ▪ Examine the timing and completeness of immunizations at specific ages ▪ Identify potential reasons immunizations were not given (i.e., "missed opportunities")
Cervical Cancer Screening	<ul style="list-style-type: none"> ▪ Look for evidence of follow-up for women who had abnormal results ▪ Document the technical adequacy of the Pap samples
Behavioral Health	<ul style="list-style-type: none"> ▪ Determine if the PCP was aware of a member's inpatient behavioral health hospitalization ▪ Determine who informed the PCP of a member's behavioral health hospitalization (e.g., behavioral health provider, member, hospital provider, etc.) ▪ Determine if the PCP saw the member within the specified timeframe after discharge

3.6 Using Data for QI without Providing Rewards or Sanctions

Initially, Massachusetts had intended to provide rewards for QI or sanctions for poor performance. However, over time, Massachusetts has become very cautious about tying any performance incentives to the profiling activities in either the PCC or MCO Plans. DMA staff clearly understand that claims-based data are not a complete source of information about services provided and approach working with their providers with this understanding. To date, DMA does not tie financial incentives to the profile results and is cautious in considering implementing any sanctions, such as closing off new enrollments. Given the potential limitations or inaccuracies of the data (e.g., services not identified due to billing errors and the debate over who should be counted as part of a provider's panel), DMA was considering sanctions based on commitment to QI activities, for example for low performing providers who do not meet with the PIMS staff or who do not follow through with their Action Plans. However, even this may not be implemented, as policy makers are concerned about a possible negative impact on access to care under the PCC Plan.

In addition, while Massachusetts has received attention for its value-based purchasing approach with managed care plans, the state has not actually instituted any changes in payment in relation to compliance with QI requirements or in relation to quality outcomes. This is not surprising in a market characterized by plan withdrawals.

4. EVALUATION OF THE PCC PLAN PROFILING INITIATIVE

4.1 Overview

As we described in Chapter 3, the PCC Plan Profiling Initiative is an extensive and resource intensive activity. In 2002, DMA reported 4.36 full time equivalent staff positions for QM/QI in the PCC Plan, used substantial computer resources for generating the profile reports from claims, and incurred printing costs for the educational materials developed and distributed (\$48,000 was spent between July 2000 and June 2001 on program support materials). In addition, the current PIMS contract is for \$1.1 million dollars. To what effect are these efforts? To evaluate the impact of these activities, we reviewed an evaluation commissioned by Massachusetts in 1999, spoke with DMA and PIMS staff, and interviewed the staff at 14 PCC Plan practices. Our goals were to evaluate the impact on physician behaviors, provider burden, and gather providers' perspectives on the activities.

4.2 Analysis of Measurable Impacts on Physician Behavior

The state commissioned an evaluation of the PCC profiling activities in 1999, including a survey of PCCs and review of Profile data at several points in time. The authors found little evidence of an impact on physician behavior as measured by trends in the Profile Reports (Friedman *et al.*, 1999). DMA and PIMS staff attribute the lack of measurable impact on the rates to several factors, many outside the control of the PCC Plan practices. First, refinements have been made to the measures over time. These include changes in the claims specifications to improve the measures (e.g., to avoid including trauma-related emergency room visits), or to the defined data collection periods, and changes resulting from new clinical standards, such as changes in the EPSDT schedule. These refinements improve measures for the future, at the cost of comparability between profile data in the short run. Lack of visible progress is also attributed to short beneficiary enrollment periods, to movement of practices in and out of the PCC Plan in response to changes in the managed care market (i.e., when an MCO exited the market and physicians joined the PCC Plan to continue to serve their Medicaid patients) and to cultural barriers to patient compliance with some of the recommended services. Finally, the measurement and improvement cycle is long; data collection, claims analysis, report production, review with the PCCs, Action Plan selection, development and implementation, and follow-up profiling span several years. Thus, although the PCC Plan first implemented profiling in 1995, it may still be too early to have achieved a measurable impact on specific service rates.

While these factors explain the limited ability of the profiling initiative to show any impact on performance, PIMS staff also reported that the providers vary in the resources that they have available and their commitment to implementing action plans.

4.3 The Provider Perspective

Table 2 provides descriptive information about the PCC Plan practices that we interviewed (see Chapter 2 for details about the methodology). As shown in the table, we interviewed three solo practitioners and staff at three community health centers, five group practices, and three hospital outpatient departments. The practices served as few as 370 to as

many as 7,356 MassHealth beneficiaries with the percent of their patients who were MassHealth enrollees ranging from 4% to 80%. Most, but not all, of their MassHealth patients were enrolled in the PCC Plan (not shown). Their remaining patients were either enrolled in an MCO, or remained in fee-for-service. Combined, these 14 practices serve 35,000 MassHealth enrollees, about 9% of the total enrollment.

Table 2
Characteristics of the PCC plan practices interviewed

<u>Type of Practice</u>	<u>Number of MassHealth Patients In Practice Panel*</u>	<u>MassHealth Members as % of Practice**</u>
Solo Practice	1,697	≥ 55
Solo Practice	529	≥ 80
Solo Practice	370	45
Community Health Center	1,957	≥ 30
Community Health Center	1,489	≥ 15
Community Health Center	1,704	40
Group Practice	3,299	4
Group Practice	757	5
Group Practice	975	≥ 45
Group Practice	1,447	≥ 50
Group Practice	4,090	71
Hospital Outpatient Department	5,982	10
Hospital Outpatient Department	4,219	7
Hospital Outpatient Department (Pediatric)	7,356	≥ 60

* Division of Medical Assistance Enrollment Files

** Estimates provided by each practice

In Table 3, we present information about who oversees QI activities in each of these practices, i.e., meets with PIMS staff and is responsible for communicating QM/QI information with others in the practice and for implementation of the resulting QI activities. As seen in the table, practices varied in the type of staff involved and their respective level of involvement. While clinical staff participated in many of the practices interviewed, in some cases only administrative staff attend the meetings at which the Profile Reports are reviewed and improvement activities determined. In one group practice, a nurse practitioner meets with the PIMS staff but reported that she has no real influence on implementing changes based on the meetings, and another identified challenges sharing the information across multiple offices in a large group practice. In larger organizations, meeting with PIMS staff and designing action plans is a small component of much larger systems oriented toward monitoring and improving care.

Table 3
Oversight of QI activities within each practice

<u>Type of Practice</u>	<u>Who Oversees QI Activities?</u>
Solo Practice	Practice Manager
Solo Practice	Physician
Solo Practice	Physician and office staff
Group Practice	Office Manager
Group Practice	Risk Manager, Manager of Managed Care, Community Medical Director
Group Practice	Group Practice Managers (3)
Group Practice	No one - a nurse practitioner meets with PIMS staff.
Group Practice	Assistant Executive Director, Nurse Manager
Community Health Center	Nurse Manager, Patient Account Manager, Medical Director
Community Health Center	Executive Director, Nurse Manager, Medical Director
Community Health Center	Assistant Director of Programs
Hospital Outpatient Department	Director of Medicaid/Uncompensated Care Pool, Administrative Director of Adult Services, Administrative Director of Child Services, Pediatrician Medicaid Director, Data Support Staff
Hospital Outpatient Department	Independent Physician Association Assistant Director, and the President of the Physician's Group
Hospital Outpatient Department (Pediatric)	Director of Maternal Child Health Services, Medical Director, Nurse Practitioner, Pediatrician, Nurses (2)

In response to an open-ended question about positive aspects of the profiling initiative, the practices described various benefits and ways it has changed their operations. As seen in Table 4, eight of the practices value the opportunity to observe their own patterns of care delivery for their MassHealth patients. Specifically, several practice staff mentioned it was helpful to see trends in their patients' use of emergency room services for asthma. One large practice reported the information assisted their staff to realize the magnitude of emergency room utilization among their patients. Seven practices interviewed rely on the data from MassHealth to help them track individuals in need of routine care, while one stated the reports help them track individual patients' drug-seeking behaviors through emergency room visits. Practice staff also praised the educational support materials provided by MassHealth ("The brochures are great, patients love them"), mentioning the translations into various languages and indicating their favorites, including the "Healthy Kid Book," diabetic information card, immunization schedule magnet, and asthma management materials. Some practices reported using these materials with their commercial patients as well as their MassHealth patients. One practice reported relying on the provider educational materials for updated information about treatment guidelines.

Table 4
Benefits to practices of profiling initiative

	<u>Observe Patterns Care across Practice</u>	<u>Track Needed Care for Individuals</u>	<u>Use Educational Materials with Patients</u>
Solo n=3	2	2	1
Group n=5	2	3	3
CHC n=3	1	2	3
OPD n=3	3	0	1
Total = 14	8	7	7

Many had redesigned aspects of their practice activities as a result of the PCC Plan Profile and Action Plan activities. Most commonly, they had implemented recall and reminder systems for the first time in their practice and used the educational materials with their patients. Almost all of them reported using the information to help them track patients in need of particular services. Almost all of them also reported using the information with their patients. Finding ways to systematically increase delivery of needed care is challenging to these providers, especially those lacking computerized systems to identify individuals due for specific services. Practices had designed special forms or added components to routine assessment forms to flag the records of patients needing services. However, some of the changes target improving billing accuracy (i.e., ensuring that services delivered are indicated on submitted claims), thereby

increasing the profile rates but not necessarily increasing service delivery rates. Other changes aim to decrease the burden on the practices of investigating whether individuals who were flagged by the Profile Report actually need services. For example, one practice placed stickers on the medical records to indicate a service had been delivered so that the medical record need not be reviewed for that service.

Few clinicians or practice managers attend the quarterly PCC Plan regional meetings (recently replaced with smaller, more targeted quality forums). Those who had attended found them useful as a means of exchanging information. The site visits from the PIMS staff may achieve the same goals in a way that is more targeted to the needs of individual practices and less time consuming. In addition, DMA expects better attendance at their newly designed quality forums that will focus on specific service delivery issues.

Provider viewpoints regarding the value of the Profile Reports specifically were more varied, differing in large part by the size and resources of the practices. Smaller practices, with little or no ability to generate reports of their own, found the profiling activities especially valuable. In contrast, hospital outpatient departments, with substantial resources for tracking patient care, did not find the profiling reports as valuable. Those with a large number of PCC Plan members on their panels invest substantial time tracking down individual records to distinguish those who did indeed receive services, but did not appear in the profile rates, from those who actually did not receive the recommended care. To the extent this activity uncovers individuals in need of service, providers feel the time is well spent. However, providers report that a substantial amount of this tracking only turns up cases where the service was indeed delivered. Of these, some were motivated to identify every possible need for follow-up with their patients and willing to accept that the profile data would include people who had already received care. For others, the inaccuracies lead to a general disregard for the value of the measures even as a starting point for discussion.

PCCs are expected to contact beneficiaries who have not received needed services. DMA provides beneficiary contact information to support this activity, and the new, more timely Reminder Reports are a very well-received enhancement to this process. However, the contact information in DMA's database is often incomplete, or inaccurate, and is a source of great frustration to the PCCs. It is not clear why these data are inaccurate. DMA staff attribute the inaccuracies to frequent changes in address or phone number in their beneficiary population that are not reported to DMA.

The lack of accurate contact information from DMA is only one aspect of a larger disagreement between the state and the practices about who should be included in the denominator for service rate calculations. All PCC Plan members either choose or are assigned to a PCC provider, yet not all come in to the PCC's office to be seen. The PCC Plan requires providers to contact new patients to schedule an initial visit, or to follow-up as needed; however, the address and telephone numbers provided by DMA are often incorrect. From the physicians' perspective, individuals who did not choose the provider (e.g., the 20% who are assigned by an automatic process), who cannot be contacted, or who do not respond to outreach efforts are not their patients. The physicians would like to see these beneficiaries removed from their panels and hence from the denominator in rate calculations. DMA acknowledges that there are

problems with the accuracy of the contact information that providers receive and that outreach is challenging. However, the state considers these beneficiaries part of the overall PCC Plan panel and considers their assignments to individual practices meaningful. From the state perspective, it is important to include these beneficiaries in the rate calculations while realizing that the practices cannot be held responsible for outreach to patients who cannot be located.

The lag between the profile periods and dissemination of the Profile Reports is also a sticking point for some PCCs. As we discussed in Chapter 1, claims-based approaches to monitoring quality are subject to substantial lags as the claims may trickle in over several months, the adjudication process can be slow, and state information systems may have trouble handling the volume, or the key departments may be understaffed. For example, the PCC Profile Reports received in the fall of 2001 reflect activity from calendar year 2000. From a state perspective, this may be acceptable, as the goal is to look at the patterns across providers or for the total enrollment, and a delay of a year is not problematic. However, providers are less interested in looking at their past performance, especially if they already consider the data inaccurate, and are most interested in information that can help them address individuals in need of service in the present. In addition, as they review patient records, providers often find that the missed service has since been delivered, albeit outside of the recommended time period. While the time period may be important for some services, for others a delay of several months may be trivial, or the service may have occurred within days of the cut-off for measurement. This reinforces some providers' view that the information does not reflect the needs of their patients or accurately represent their present performance.

The practice staff we interviewed spoke highly of the site visit process, despite the mixed views regarding the Profile Reports and Action Plans. They expressed appreciation for the communication and negotiation skills of the PIMS staff and their understanding of practice operations, the population served, and the limitations of the profile data they were presenting.

Our informants had mixed views regarding the burden associated with participating in the PCC Plan QI activities. In most cases, a practice manager or administrator, rather than physicians, participated in the PIMS site visits and was responsible for follow through. Smaller practices reported that the follow-through, including checking on cases that may need outreach, or devising and implementing Action Plans, was not burdensome, and was basically worthwhile. Practices reported incorporating the follow-up tasks into their ongoing office procedures so that they could not estimate the time spent. Some of the larger practices, however, found the process more burdensome, as more staff (sometimes across multiple sites) needed to be involved after each site visit to review the materials, organize follow-up activities, and develop and implement Action Plans. One informant expressed frustration with the administrative burden given the Medicaid payment rates and the need to meet the varying QI requirements of multiple payers.

Challenges. In summary, as shown in Figure 7, the providers, PCC Plan and PIMS staff identified challenges to quality improvement at the practice, state, and beneficiary level. Medical practices need designated staff responsible for implementing change and the infrastructure and information systems to support new approaches to care, but not all have established this type of infrastructure. Multi-site group practices found this particularly challenging as it requires involving staff from each site. In addition, large medical practices with

multiple sites may have to address differences in procedures and culture across sites. Larger provider groups may be contracting with several MCOs, each with different QI requirements. At the state level, inherent limits of claims-based profiling decrease the salience and credibility of the data to some providers in turn creating resistance to participation in QI activities. In addition, providers cannot conduct effective outreach if the state cannot provide up-to-date contact information for beneficiaries. Finally, there are beneficiary level challenges to improving processes of care. Short eligibility periods give physicians little time to deliver needed services to individual patients, and for some there are cultural barriers to the use of recommended services.

Figure 7
Challenges to quality improvement

Practice-level challenges

- Need for designated staff with responsibility for implementing changes
- Need for infrastructure and information systems to facilitate new approaches
- Multiple sites of larger provider groups may have different procedures and culture
- Varying requirements of multiple payers

State-level challenges

- Inherent limits of data (see Figure 2) decrease salience and credibility of data to providers
- Selecting appropriate measures and determining consistent data specifications
- Need for up-to-date beneficiary contact information to assist providers with outreach

Beneficiary-level challenges

- Lack of stability in Medicaid population
- Cultural barriers to compliance with some recommended services

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

In this study, we described the range of quality measurement and improvement activities conducted by the Massachusetts Medicaid program and sought to evaluate the impact of those activities on primary care case management practices. Massachusetts is actively incorporating managed care practices in a primary care case management program, as well as requiring MCOs contracting with MassHealth to pursue QM/QI activities. The state invests heavily in these activities, dedicating staff time to set goals, to develop the initiatives, to generate data and educational materials, and to work directly with the MCOs and the network management vendor for the PCC Plan activities. However, it is difficult to quantify the impact on outcomes in either the PCC or MCO Plans. The lack of observable change (Friedman, et al, 1999) is at least partly a function of the lengthy quality improvement cycle, as it can take several years to collect and analyze the baseline data, provide feedback to the medical practices, develop and implement interventions, and then repeat the data collection and analysis. Other obstacles to measurable quality improvement include changes in measure specification that do not permit meaningful comparisons across years, relatively short beneficiary eligibility spells, and problems inherent in claims-based performance measurement. The changes some PCC Plan providers report in their practice as a result of the QI efforts, such as implementing recall and reminder systems, suggest that improvements should become observable over time. In addition, there are many MassHealth beneficiaries who are not directly affected by these activities. There are many beneficiaries who remain in straight fee-for-service, and some enrolled with a PCC Plan provider who is not included in the QM/QI activities due to having fewer than 200 PCC Plan enrollees on their panels.

Despite these limitations, it is clear that DMA's PCC Plan QM/QI program has real strengths, as well as problems that other Medicaid agencies should consider in approaching similar QI strategies. The strengths include: use of process measures that are credible to providers and which they can address; a well-developed system of working with individual medical practices and tailoring QI plans to each practice; network management staff who work effectively with the medical practices; provision of useful beneficiary education materials; and redesign of DMA's own procedures in response to feedback from the PCC Plan providers. Clinical involvement in the selection and development of the measures and in working with the practices contributes to the appropriateness of the activities and the positive response from many providers. The collaborative approach taken with practices to understand what factors contribute to the reported service rates and to develop Action Plans is consistent with QI principles including creating an open, safe environment, encouraging diverse viewpoints, and negotiating agreements. Providers are very pleased with the recently revised and more timely Reminder Reports that provide the names of patients who may be in need of follow-up. Perhaps most important, DMA understands the limitations of the profile data and use these data as a starting point for dialog with individual medical practices, not as the basis for rewards or sanctions.

Weaknesses or limitations include those that all states or payers face in the use of claims-based profiling and some specific to Massachusetts. Limitations to the accuracy of claims-based profiling are clear, and many are unavoidable. Claims reflect services billed for, not all services delivered. Services may be provided, but not within the timeframe specified, and billing errors can also contribute to under-reporting of services actually provided. While performance measures provide some insight into the quality of care delivered, they have limited utility as a quality improvement tool because there are other systems issues at play and because providers need additional guidance and support to improve the quality of service delivered. The lack of up-to-date addresses and telephone numbers for beneficiaries who may be in need of follow-up is the single most frustrating issue for PCC Plan providers trying to conduct effective outreach. There is a substantial lag time between the periods of performance and dissemination of the profiles, decreasing the salience of the information to providers. While more timely reports designed to enhance outreach activities address many of the providers' concerns about the data lags regarding individual patients who may need follow-up, there may be other ways the time line for the routine profiling reports could be reduced if the resources were available. In addition, by approaching all practices with the same level of intensity, regardless of size, performance, or access to other ways to analyze their own performance, Massachusetts may not be targeting its efforts most effectively. As a result, state resources may not be used most efficiently and large practices with internal QM/QI procedures feel time spent on PCC Plan activities is redundant.

5.2 Recommendations for Other States

5.2.1 Develop a Collaborative Model for QI

Providers were generally happy with the collaborative approach that Massachusetts implements using Regional Network Managers (RNMs) who meet individually with each practice onsite twice a year. Through repeated visits, the practice staff and RNMs develop a rapport, and in most cases, succeed in developing mutually agreed upon Action Plans with the providers. The advice from Massachusetts is to invest in these relationships, focusing early visits more on getting to know each practice's operations and understanding the challenges each practice faces than on designing and implementing changes. The patient and provider educational materials provided by the state in the course of the biannual meetings provide concrete and valued support to providers trying to educate their patients about their conditions and encourage their patients to adhere to treatment regimes and understand their medical coverage. In addition, responding to feedback from the providers, Massachusetts has redesigned some of its own activities: replacing poorly attended quarterly meetings with more focused forums, as well as creating updated reports of patients in need of follow-up.

5.2.2 Appreciate the Limitations of the Data

It is clear that claims-based data are not a complete source of information about services provided. Other states would be well advised to approach working with their providers with this understanding. Providers will not hesitate to point out the limitations of the data, and a state will have more credibility and hence a greater impact on provider behavior if these limitations are acknowledged up front. In addition, because of the limitations of claims data, like

Massachusetts, states should approach providing incentives or rewards tied to performance very cautiously.

As Massachusetts has found, many providers are more focused on information with immediate applications to their patients' well-being than on retrospective data about the overall performance of a clinical practice. By the time paid claims are adjudicated, analyzed, and profiles created and disseminated, the detail about individual patients' care is out of date. Massachusetts' approach to providing more recent backup data about patients in need of care (updated from the data used to create the profiles) takes a profiling initiative designed to measure quality the next step to a clinical management tool that supports physicians to identify and reach out to patients in need of routine preventive care.

5.2.3 Select and Specify Measures Using Existing Definitions Wherever Possible

As more organizations use claims-based approaches to QM and QI, it will become easier for states to avoid reinventing the wheel, changing specifications so that measures are inconsistent across years, or burdening their providers with different measures than are used by other MCOs with whom the providers may be contracting.

5.2.4 Target Activities to Maximize Impact while Managing State Costs

Massachusetts is investing more resources in these activities than are available in many other states. Indeed, whether Massachusetts can sustain the current level of investment given recent budget pressures remains to be seen. States with fewer resources to draw upon should consider developing fewer measures, e.g., focusing on well-child visits, and more targeted approaches to on-site work with individual practices. Appropriate targets would include specific provider types, such as solo practitioners with a high proportion of Medicaid beneficiaries in their panels. These providers would benefit most from the opportunity to better understand their patient panels given their own lack of information systems. Alternatively, a state could focus on practices whose profiles suggest poor performance. Even though claims-based profile measures are imperfect, they can be used to identify practices who may be performing particularly poorly.

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